कार्यरत व सेवानिवृत्त राज्य शासकीय अधिकारी/कर्मचारी आणि कार्यरत व सेवानिवृत्त अखिल भारतीय सेवेतील अधिकारी यांचे करिता वैद्यकीय प्रतिपूर्तीची विमाछत्र योजनेचे नुतनीकरण

महाराष्ट्र शासन

वित्त विभाग

शासन निर्णय क्रमांक संकीर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा प्रशा-४

मादाम कामा मार्ग, हुतात्मा राजगुरु चौक,
मंत्रालय, मुंबई ४०० ०३२.
दिनांक :-२३ जुलै, २०२४.

वाचा : (१) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/२०१४/कोषा प्रशा-४, दि.०९.०७.२०१४.
(२) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/२०१४/कोषा प्रशा-४, दि.२५.०६.२०१५.
(३) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/२०१४/ कोषा प्रशा-४, दि.२८.०६.२०१६.
(४) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग -१/२०१४/कोषा प्रशा-४, दि.१७.०७.२०१७.
(५) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१६.०७.२०१८.
(६) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१९.०७.२०१९.
(७) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१३.०७.२०२०.
(८) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१६.०७.२०२१.
(९) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.२१.०७.२०२२.
(१०) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.२४.०७.२०२३.

प्रस्तावना-

उपरोक्त वाचा मधील अनुक्रमांक १ येथील शासन निर्णयान्वये, कार्यरत व सेवानिवृत्त राज्य शासकीय अधिकारी/कर्मचारी आणि अखिल भारतीय सेवेतील कार्यरत व सेवानिवृत्त अधिकारी तसेच दि.३०.०६.२०११ नंतर सेवानिवृत्त झालेले शासकीय अधिकारी/कर्मचारी व कुटूंब निवृत्तीवेतनधारक यांचेकरिता गटविमा तत्वावर आधारित वैद्यकीय प्रतिपूर्तीची विमाछत्र योजना सन २०१४-१५ पासून लागू करण्यात आली आहे. उपरोक्त वाचा मधील अनुक्रमांक २ ते १० येथील शासन निर्णयांन्वये सदर योजनेला वेळोवेळी मुदतवाढ देण्यात आलेली आहे. सद्यस्थितीत दि.२५.०७.२०२४ ते दि.२४.०७.२०२५ या कालावधीसाठी सदर योजनेचे नुतनीकरण करण्याची बाब शासनाच्या विचाराधीन होती.

शासन निर्णय

कार्यरत व सेवानिवृत्त अधिकारी/कर्मचारी आणि अखिल भारतीय सेवेतील कार्यरत व सेवानिवृत्त अधिकारी यांचेकरिता सुरु असलेल्या वैद्यकिय प्रतिपूर्तीच्या विमाछत्र योजनेचे दि.२५.०७.२०२४ ते दि.२४.०७.२०२५ या कालावधीसाठी नुतनीकरणास मान्यता देण्यात येत आहे. प्रस्तुत वैद्यकीय प्रतिपूर्तीची विमाछत्र योजना कार्यरत आणि सेवानिवृत्त अधिकारी/कर्मचारी तसेच अखिल भारतीय सेवेतील अधिकारी यांना सक्तीची राहणार नसून, स्वेच्छेने आवश्यक तो वार्षिक हप्ता भरून संबंधित अधिकारी/कर्मचारी/निवृत्तीवेतन धारक या योजनेमध्ये सहभागी होऊ शकतील. तसेच या योजनेत केवळ दि.१ जुलै, २०२४ ते दि.३० जून, २०२५ या कालावधीत सेवानिवृत्त झालेले/होणारे अधिकारी/कर्मचारी आणि अखिल भारतीय सेवेतील अधिकारी स्वेच्छेने आवश्यक तो वार्षिक हप्ता भरुन या योजनेमध्ये सहभागी

होण्यास पात्र ठरतील. त्याचप्रमाणे योजनेमध्ये गतवर्षी समाविष्ट असलेले सर्व सदस्य नुतनीकरण करण्यासाठी पात्र ठरतील.

२. सन २०२३-२४ मध्ये सदर योजनेंतर्गत विमा कंपनीकडे एकूण विमा हप्ता रक्कम रू.२२.६० कोटी जमा झाला आहे. तसेच दिनांक १५.०६.२०२४ पर्यंत Incurred Claim Ratio ८१% इतका झाला आहे. अद्याप पॉलिसीची मुदत दिनांक २४.०७.२०२४ पर्यंत शिल्लक असल्याने उर्वरित कालावधीत उद्भवणाऱ्या दाव्यांची संभाव्य संख्या विचारात घेता, एकंदरीत Incurred Claim Ratio १००% इतका होण्याची शक्यता विमा कंपनीने वर्तवली आहे.

३. वैद्यकीय प्रतिपूर्तीच्या विमाछत्र योजनेमध्ये सदस्य नोंदणी होण्याचे प्रमाण कमी होत असल्याने वर्ष २०२४-२५ मध्ये अधिकारी/कर्मचाऱ्यांचा सहभाग वाढावा, याकरिता कार्यरत अधिकारी/कर्मचारी यांच्या करिता वयोगट १८-३५ वर्षे, ३६-४५ वर्षे, ४६-५८ वर्षे व सेवानिवृत्त या वयोगटानुसार विमा हप्त्यांच्या दरांमध्ये बदल करण्यात येत आहेत.

४. या योजनेतर्गत समाविष्ट होणाऱ्या अधिकारी/कर्मचारी यांना वैद्यकिय चाचणीची पूर्वअट राहणार नाही. तसेच या योजनेत समावेश करतेवेळी अस्तित्वात असलेल्या आजारांनाही विमाछत्र उपलब्ध असेल. (म्हणजेच सोबत जोडलेल्या न्यू इंडिया ॲश्यूरन्स कंपनीच्या पॉलिसी डॉक्युमेंटमध्ये अ.क्र.४.१ येथील नमूद अस्तित्वात आजारांनाही विमाछत्र उपलब्ध असेल)

५. जे अधिकारी/कर्मचारी विमाछत्र योजना कालावधीमध्ये सेवानिवृत्त होणार आहेत, परंतु सदर योजनेमध्ये समाविष्ट होऊ इच्छित नाहीत, अशा अधिकारी/कर्मचाऱ्यांकडून सदर योजनेमध्ये भविष्यातही समाविष्ट न होण्याबाबतचे घोषणापत्र (Opting Out Declaration) परिशिष्ट-१ मधील विहीत नमून्यात घेण्याची दक्षता संबंधित आहरण व संवितरण अधिकारी यांनी घ्यावी. सदरचे घोषणापत्र सेवानिवृत्तीवेतन प्रकरणासोबत कोषागार कार्यालयास सादर करावे.

६. सदर योजनेमध्ये नव्याने समाविष्ट होऊ इच्छिणाऱ्या सदस्यांना ९० दिवसांचा प्रतिक्षा कालावधी असेल. तसेच सोबत जोडलेल्या परिशिष्ट-२ मधील आजारांकरिता योजनेमध्ये नव्याने समाविष्ट होऊ इच्छिणाऱ्या सदस्यांना १८ महिन्यांचा प्रतिक्षा कालावधी असेल. तसेच सदर आजारांकरिता २०% Co pay लागू राहील.

७. योजनेमध्ये गतवर्षी समाविष्ट असलेल्या सदस्यांनी चालू वर्षी कोणत्याही परिस्थितीत ३० दिवसांच्या आत विमा हप्त्याचा भरणा करुन योजनेचे नुतनीकरण करणे ही विमा धारकाची वैयक्तिक जबाबदारी राहील. ३० दिवसांच्या मुदतीनंतर योजनेचे नुतनीकरण केल्यास असा सभासद योजनेमध्ये नव्याने समाविष्ट झाल्याचे समजले जाईल. (याकरिता आहरण व संवितरण अधिकारी अथवा कोषागार अधिकारी जबाबदार असणार नाहीत.)

८. ज्या रुग्णालयांत दि न्यु इंडिया ॲश्युरन्स कंपनी लि. यांचे PPN (Preferred Provider Network) आहे, तेथे रोकडरहीत (Cashless) सुविधा उपलब्ध असेल. PPN रुग्णालया व्यतिरिक्त अन्य रुग्णालयात उपचार घेतल्यास वैद्यकिय प्रतिपूर्ती उपलब्ध राहील. जेथे PPN रुग्णालय उपलब्ध आहेत, तेथे केवळ PPN पॅकेजेस प्रतिपूर्तीसाठी ग्राहय धरली जातील.

स्पष्टीकरण:-अ) विमा धारकास कोणत्याही PPN रुग्णालयामध्ये उपचार घेण्याची मुभा असेल तथापि प्रतिपूर्ती ही विमा कंपनीच्या PPN पॅकेजेसच्या दराप्रमाणे दिली जाईल. रुग्णालयाचे दर व PPN दर यातील फरक विमा धारकाने सोसावयाचा आहे.

ब) PPN बाहेरील रुग्णालयमध्ये उपचार घेण्याचे स्वातंत्र्य विमा धारकास असेल, तथापि, अशा प्रकरणी विमा कंपनीच्या प्रचलित धोरणानुसार रुग्णालयाची अर्हता तपासून कंपनी दावा पारित करेल.

९. ज्या अधिकारी/कर्मचाऱ्यांसाठी सेवानिवृत्तीचे वय ६० वर्षे आहे, अशा अधिकारी/कर्मचाऱ्यांसाठी खालील परिच्छेद क्रमांक ११ मधील तक्ता (ड) अन्वये सेवानिवृत्त अधिकारी/कर्मचाऱ्यांसाठीचे विमा हप्त्याचे दर (GST सह) लागू राहतील.

१०. सदर शासन निर्णयाशी विसंगत नसतील, अशा, मागील वर्षांच्या योजनेतील सर्व अटी व शर्ती सन २०२४-२५ साठीच्या योजनेकरिताही लागू राहतील.

११. सन २०२४-२५ करीताचे सुधारित विमा हप्त्याचे दर **(GST सह)** पुढीलप्रमाणे राहतील.

तक्ता-(अ)

१८-३५ वर्षे वयोगटातील कार्यरत अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र.	विमा छत्र रक्कम रुपये	फक्त कर्मचारी स्वतः विमा हप्ता रुपये	१+३ (कर्मचारी, कर्मचाऱ्यांची पती/पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत) विमा हप्ता रुपये
१	१ लाख	२८७८	१६२१४
२	२ लाख	३४५५	२१३९६
३	३ लाख	४६०७	२९२३७
४	४ लाख	४९९१	३२४३७
५	५ लाख	६७१५	३७२७४
६	८ लाख	८९७०	५६८१७
७	१० लाख	१००१३	७२५१५
८	१२ लाख	१२०१५	८४११६
९	१५ लाख	१३५१७	१०९९२४
१०	२० लाख	२००२५	१४२४३३

तक्ता-(ब)

३६-४५ वर्षे वयोगटातील कार्यरत अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र.	विमा छत्र रक्कम	फक्त कर्मचारी स्वत:	१+३ (कर्मचारी, कर्मचाऱ्यांची पती/पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत)
	रुपये	विमा हप्ता रुपये	विमा हप्ता रुपये
१	१ लाख	३१६६	१७४३५
२	२ लाख	३८००	२३००५
३	३ लाख	५०६७	३१४३६
४	४ लाख	६७८९	४३१४०
५	५ लाख	७३८८	४५९८०
६	८ लाख	९८७०	६१०९३
७	१० लाख	११०१४	७७९७३
८	१२ लाख	१३२१५	९०४४८
९	१५ लाख	१४८६७	११८१९८
१०	२० लाख	२२०२६	१५३१५२

तक्ता-(क)

४६-५८ वर्षे वयोगटातील कार्यरत अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र.	विमा छत्र रक्कम	फक्त कर्मचारी स्वत:	१+३ (कर्मचारी, कर्मचाऱ्यांची पती/पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत)
	रुपये	विमा हप्ता रुपये	विमा हप्ता रुपये
१	१ लाख	३८५०	२०४३५
२	२ लाख	४०७७	२३७८५
३	३ लाख	५४३५	३२५०३
४	४ लाख	५८८८	३६०६३
५	५ लाख	७३३५	३६७१८
६	८ लाख	१२००२	७१६१२
७	१० लाख	१२९९५	८०६१६
८	१२ लाख	१४१७७	९३५१४
९	१५ लाख	१९७२६	१५१११४६
१०	२० लाख	२३६२७	१५८३४४

तक्ता-(ड)

सेवानिवृत्त अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र.	विमाछत्र रक्कम रुपये	फक्त कर्मचारी स्वत: विमा हप्ता रुपये	१+१ (निवृत्तवेतनधारकांचे पती/पत्नी) विमा हप्ता रुपये
१	१ लाख	१७८०६	२८३९८
२	२ लाख	२५७५९	४१२०६
३	३ लाख	२७७१३	४३८१३
४	४ लाख	३६८६३	६०३६८
५	५ लाख	३९६०१	६३९५८
६	८ लाख	६१००६	९८२७०
७	१० लाख	९१६९५	१४६५९५
८	१२ लाख	१०७४४५	१७१९२५
९	१५ लाख	१२९३१५	२०६८८८
१०	२० लाख	१६३४२६	२५९४४९

१२. मागील वर्षी दाव्याच्या प्रतिपूर्तीचा लाभ घेतलेले जे सदस्य चालू वर्षी नुतनीकरण करणार नाहीत, त्यांना या योजनेत भविष्यात समाविष्ट होण्यास कायमस्वरूपी प्रतिबंधित करण्यात येईल.

१३. विमा कंपनीच्या असे निर्देशनास आले आहे की, रूग्णालयात दाखल झाल्यानंतर विमा धारकाकडून त्याची माहिती त्रयस्थ प्रशासकास (TPA) विलंबाने दिली जाते. त्यामुळे दाव्याची सत्यता पडताळणी करण्यास अडचणी येतात. सबब, विमा धारकांनी प्रतिपूर्तीकरिता दावा सादर करतांना दाव्याची सूचना त्रयस्थ प्रशासकास (TPA) रुग्णालयात दाखल झाल्याच्या दिनांकापासून ७२ तासांच्या आत न दिल्यास दाव्यावर **१०% "Co Pay"** लागु राहील.

१४. विमाधारकाने आंतररुग्ण कालावधी समाप्त झाल्यानंतर (Date of Discharge) ३० दिवसांच्या आत विमा दावा विमा कंपनीस सादर करणे आवश्यक राहील. विमा दावा सादर करण्यास ३१ ते ५० दिवसांचा विलंब झाल्यास दाव्यावर २०% "Co Pay" लागू राहील. विमा दावा सादर करण्यास ५१ ते ७५ दिवसांचा विलंब झाल्यास दाव्यावर २५% "Co Pay" लागू राहील. विमा दावा सादर करण्यास ७६ ते १०० दिवसांचा विलंब झाल्यास दाव्यावर ३०% "Co Pay" लागू राहील व विमा दावा सादर करण्यास १०० दिवसांपेक्षा जास्त विलंब झाल्यास विमा दावा नाकारण्यात येईल.

१५. विमाछत्र रक्कम रु.१० लाख ते रु.२० लाख मधील विमाधारकांना रुग्णालयातील वास्तव्य खर्च (Room Rent) यासाठी अधिकतम मर्यादा (Capping) खालीलप्रमाणे असतील.

विमाछत्र रक्कम	सर्वसाधारण वास्तव्याकरिता	अतिदक्षता कक्षातील वास्तव्याकरिता
रु.१० लाख व १२ लाख	आश्वासित रकमेच्या १% व कमाल रु.८,०००/- च्या मर्यादेत प्रतिदिन	आश्वासित रकमेच्या २% व कमाल रु.१६,०००/- च्या मर्यादेमध्ये प्रतिदिन
रु. १५ लाख	आश्वासित रकमेच्या १% व कमाल रु.१०,०००/- च्या मर्यादेत प्रतिदिन	आश्वासित रकमेच्या २% व कमाल रु.२०,०००/- च्या मर्यादेत प्रतिदिन
रु.२० लाख	आश्वासित रकमेच्या १% व कमाल रु.१५,०००/- च्या मर्यादेत प्रतिदिन	आश्वासित रकमेच्या २% व कमाल रु.३०,०००/- च्या मर्यादेमध्ये प्रतिदिन

१६. विमा पॉलिसीचे नुतनीकरण करताना, विमा हप्त्याचे प्रदान विमा कंपनीस **https://easypay.axisbank.co.in/easyPay/makePayment?mid=NTg4MzQ%3D** या लिंकद्वारे करणे बंधनकारक असणार आहे. सदर पेमेंट लिंकचा वापर करुन NEFT/RTGS/UPI अथवा Credit Card द्वारे विमा हप्त्याचे प्रदान करता येऊ शकते**. मात्र सदर लिंकद्वारे Debit card द्वारे विमा हप्ता प्रदान करता येऊ शकणार नाही.**

१७. योजनेमध्ये नुतनीकरणासाठी उपरोक्त लिंक संबंधित विमाधारकास SMS द्वारे भ्रमण दूरध्वनीवर (Mobile Phone) अथवा ई-मेलद्वारे प्राप्त होणार आहे, अशा प्रकारची लिंक प्राप्त न झाल्यास The New India Assurance Co. Ltd. यांचेशी ८६५२४३५९३४/०२२-२६५९००७० या क्रमांकावर संपर्क साधावा.

१८. सदर योजनेमध्ये नवीन नोंदणी करण्यासाठी संबंधितांनी खालील परिच्छेद क्रमांक २० मध्ये नमूद संचालक, लेखा व कोषागारे यांचेद्वारा प्रसृत परिपत्रकाद्वारे विहीत करण्यात आलेली कार्यपध्दती अनुसरावयाची आहे. नवीन नोंदणीसाठी अधिदान व लेखा कार्यालय/कोषागार कार्यालय आणि आहरण व संवितरण अधिकारी यांनी विमाधारकाची व विमा हप्ता प्रदानाची अचूक माहिती Web Form द्वारे विमा कंपनीस कळवावी. वय वर्ष ३६ व त्यापुढे वय असणाऱ्या विवाहीत अधिकारी/कर्मचाऱ्यांना सदर योजनेमध्ये नवीन नोंदणी व नुतनीकरण करतांना १+३ या पर्यायाचा अवलंब करावा लागणार आहे.

१९. तसेच या योजनेमधील वैद्यकीय दाव्यांसंदर्भात अथवा रोकडरहीत (Cashless) सुविधेबाबत कर्मचारी/अधिकारी/निवृत्तीवेतनधारक यांना काही शंका असल्यास MD India (TPA-त्रयस्थ प्रशासक) यांचेशी Toll Free No. १८००-२०९-७७७७/१८००-२०९-७८०० अथवा ९३७०५५०४४९ या भ्रमणध्वनी क्रमांकावर संपर्क साधता येईल. तसेच विमा हप्ता भरण्यासंदर्भात काही शंका असल्यास The New India Assurance Co. Ltd. यांचेशी ८६५२४३५९३४/०२२-२६५९००७० या क्रमांकावर संपर्क साधता येईल.

२०. सदर योजनेच्या सविस्तर कार्यपध्दतीबाबत संचालक (लेखा व कोषागारे), मुंबई यांनी निर्गमित केलेल्या सूचना https://mahakosh.maharashtra.gov.in या संकेतस्थळावरील Circular & Order या पर्यायाखाली उपलब्ध असतील. सदर योजनेच्या अनुषंगाने दि न्यु ॲश्युरन्स कंपनीचे Policy Document यासोबत परिशिष्ट-३ येथे उपलब्ध करुन देण्यात येत आहे.

सदर शासन निर्णय महाराष्ट्र शासनाच्या www.maharashtra.gov.in या संकेतस्थळावर उपलब्ध करण्यात आला असून त्याचा संगणक सांकेतांक क्र. २०२४०७२३१०४१११९६०५ असा आहे. हा शासन निर्णय डिजीटल स्वाक्षरीने साक्षांकित करुन काढण्यात येत आहे.

महाराष्ट्राचे राज्यपाल यांच्या आदेशानुसार व नांवाने,

DR RAJENDRA UTTAMRAO GADEKAR

Digitally signed by DR RAJENDRA UTTAMRAO GADEKAR
DN: c=IN, o=GOVERNMENT OF MAHARASHTRA, ou=FINANCE DEPARTMENT, 2.5.4.20=b8e8c3a034acb70f16af6f81c69ca038ff6f25ff78cfc9e6d815fd95b5367b07, postalCode=400032, st=Maharashtra, serialNumber=37A42E182BACE4C129ABBEB54E27836D32D401560638F644A547867205474EE5, cn=DR RAJENDRA UTTAMRAO GADEKAR
Date: 2024.07.23 10:55:18 +05'30'

(डॉ.राजेंद्र गाडेकर)
शासनाचे उप सचिव

प्रति,

१. मा.राज्यपाल यांचे सचिव
२. मा.मुख्यमंत्री यांचे अपर मुख्य सचिव,
३. मा.उप मुख्यमंत्री (गृह) यांचे सचिव,
४. मा. उप मुख्यमंत्री (वित्त व नियोजन) यांचे सचिव,
५. सर्व मा.मंत्री व मा.राज्यमंत्री यांचे खाजगी सचिव
६. मा.विरोधी पक्षनेता, विधानसभा / विधान परिषद, महाराष्ट्र विधानमंडळ सचिवालय,मुंबई.
७. सर्व सन्माननीय विधानसभा / विधान परिषद व संसद सदस्य.
८. अ.मु.स/प्र.स./सचिव ,सर्व मंत्रालयीन प्रशासकीय विभाग,
९. सर्व मंत्रालयीन प्रशासकीय विभागांच्या अधिनस्त असलेले सर्व विभाग प्रमुख, प्रादेशिक कार्यालय प्रमुख व कार्यालय प्रमुख,
१०. प्रबंधक, मूळ न्यायालय शाखा, उच्च न्यायालय, मुंबई
११. प्रधान महालेखापाल (लेखा परीक्षा)- १, महाराष्ट्र, मुंबई
१२. प्रधान महालेखापाल (लेखा व अनुज्ञेयता)-१, महाराष्ट्र, मुंबई
१३. महालेखापाल (लेखापरीक्षा)-२, महाराष्ट्र, नागपूर
१४. महालेखापाल (लेखा व अनुज्ञेयता)-२, महाराष्ट्र, नागपूर
१५. आयुक्त, आयकर (TDS) चर्नीरोड, मुंबई ४००००२
१६. आयुक्त, आयकर (TDS) सिव्हील लाईन*, नागपूर ४४४००१
१७. प्रबंधक, उच्च न्यायालय (अपील शाखा) मुंबई
१८.सचिव, महाराष्ट्र लोकसेवा आयोग, मुंबई,
१९.सचिव, महाराष्ट्र विधीमंडळ सचिवालय, मुंबई
२०.प्रबंधक, लोक आयुक्त व उपलोक आयुक्त यांचे कार्यालय, मुंबई,
२१.प्रबंधक,महाराष्ट्र प्रशासकीय न्यायाधिकरण,मुंबई,
२२.मुख्य माहिती आयुक्त, महाराष्ट्र राज्य, मुंबई,
२३.विशेष आयुक्त, महाराष्ट्र सदन, कोपर्निकस रोड, नवी दिल्ली,
२४.सर्व विभागीय आयुक्त,
२५.सर्व जिल्हाधिकारी,
२६.सर्व जिल्हा परिषदांचे मुख्य कार्यकारी अधिकारी,
२७.संचालक, लेखा व कोषागारे, मुंबई,
२८.अधिदान व लेखा अधिकारी, मुंबई,
२९.प्रादेशिक सह संचालक,लेखा व कोषागारे,कोकण/पुणे/ नाशिक/छत्रपती संभाजीनगर/

अमरावती/नागपूर

३०.संचालक,स्थानिक निधी लेखापरिक्षा संचालनालय, नवी मुंबई,

३१.प्रादेशिक सह संचालक,स्थानिक निधी लेखापरीक्षा कोकण/पुणे/नाशिक/ छत्रपती संभाजीनगर/ अमरावती/ नागपूर,

३२.वरिष्ठ जिल्हा कोषागार अधिकारी, ठाणे / पुणे / नाशिक / छत्रपती संभाजी नगर / अमरावती/नागपूर

३३.सर्व जिल्हा कोषागार अधिकारी,

३४.सर्व उप कोषागार अधिकारी,

३५. वित्त विभागातील सर्व कार्यासने,

३६.निवड नस्ती/कोषा प्रशा-४

शासन निर्णय क्रमांक संकीर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा-प्रशा-४, दि.२३ जुलै,२०२४ सोबतचे सहपत्र

परिशिष्ट-१

घोषणापत्र (Opting Out Declaration)

१. मी, श्री./श्रीम.---

पीपीओ क्र.----------------------अन्य वैद्यकीय विमा कंपनी--------------------------------

---------------- चा सभासद **आहे/नाही**.

२. मी, श्री./श्रीम.--------------------------------- घोषित करतो/करते की, मी राज्य शासनाच्या वैद्यकीय प्रतिपूर्तीच्या विमाछत्र योजनेमध्ये सहभागी होऊ इच्छित नसून भविष्यात देखील या योजनेमध्ये सहभागी होण्याची मागणी करणार नाही.

आपला,

अधिकारी/कर्मचारी यांची स्वाक्षरी

नावः-

पदनामः-

कार्यालयाचे नावः-

शासन निर्णय क्रमांक संकीर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा-प्रशा-४, दि.२३ जुलै, २०२४ सोबतचे सहपत्र

परिशिष्ट-२

LIST OF ILLNESS/PROCEDURE

- **Cardiology & Heart Surgery :-** Bypass Surgery, Open Heart Surgery, Valve replacement or repair, Congenital disease & related surgery, Baloon, Volvoplasty. Permanent Pacemaker, Stent. PTCA.
- **Orthopaedic Surgery TKR :-** Total Knee Replacement, THR - Total Hip Replacement-Reduction of Fracture, Orthoscopic Repair of Ligaments of Knee.
- **Nephrology** Urology (Renal Transplant, Lithotripsy)
- **Oncology** Surgical Management, Radiation, Chemotherapy
- **Neurology** cerebrovascular Surgery, Scull base surgery, Brain Tumour, Intratactablay surgery, congenital defects related epilepsy surgery such as Hydrocephalus Guilin Bar syndrome.
- **Ophthalmology :-** Glucoma surgery, Detachment of Retina, Simple surgery, Keratoplasty, Vitrectomy, Laser treatment
- **Vascular Surgery**
- **Internal Medicine** Upper Airway Obstruction
- **Gastroenterology** GE Tract, Laparoscopic cholecystectomy
- **ENT** Ear Nose Throat related treatments
- **General** Brain Fever, PUO
- Hernia/Hysterectomy- actual expenses or 25% of sum insured whichever is less.
- Cataract- Actual expenses or maximum Rs. 24,000 for Mumbai, Navi Mumbai & Thane & Rs.18,000 for rest of Maharashtra.

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शासन निर्णय क्रमांक संकीर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा-प्रशा-४, दि.२३ जुलै, २०२४ सोबतचे सहपत्र

परिशिष्ट-३

THE NEW INDIA ASSURANCE CO. LTD

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400 001

NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY

1.0 PREAMBLE

Whereas Insured designated in the Schedule hereto has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to THE NEW INDIA ASSURANCE CO. LTD. (hereinafter called the COMPANY) for the insurance herein after set forth in respect of Employees/Members (including their eligible Family Members) named in the Schedule hereto (herein after called the INSURED PERSON) and has paid premium as consideration for such insurance

2.0 DEFINITIONS

STANDARD DEFINITIONS

2.1 **ACCIDENT** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 **ANY ONE ILLNESS** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital where treatment may have been taken.

2.3 **AYUSH HOSPITAL** is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- **a.** Central or State Government AYUSH Hospital or
- **b.** Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
- **c.** AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
  - **i.** Having at least 5 in-patient beds;
  - **ii.** Having qualified AYUSH Medical Practitioner in charge round the clock;
  - **iii.** Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
  - **iv.** Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.4 **AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment

procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 **CASHLESS FACILITY** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the network provider by the Company to the extent pre-authorization approved.

2.6 **CONDITION PRECEDENT:** Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

2.7 **CONGENITAL ANOMALY:** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

i. **CONGENITAL INTERNAL ANOMALY** means a Congenital Anomaly which is not in the visible and accessible parts of the body.
ii. **CONGENITAL EXTERNAL ANOMALY** means a Congenital Anomaly which is in the visible and accessible parts of the body

2.8 **DAY CARE CENTRE:** A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment;
- Has qualified medical practitioner/s in charge;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.9 **DAY CARE TREATMENT** refers to medical treatment or Surgery which are:

- Undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and
- Which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

2.10 **DENTAL TREATMENT** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery / implants.

2.11 **DISCLOSURE TO INFORMATION NORM**: The policy shall be void and all premium paid thereon shall be forfeited to Us in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.12 **EMERGENCY CARE** means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured Person's health.

2.13 **GRACE PERIOD** means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

2.14 **HOSPITAL** means any institution established for Inpatient Care and Day Care treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

The term 'Hospital' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

2.15 **HOSPITALISATION** means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Haemo-Dialysis	Tonsillectomy,
Hydrocele	Urinary Tract System

OR any other Surgeries / Procedures agreed by TPA/Company which require less than 24 hours hospitalization due to advancement in Medical Technology.

2.16 **ILLNESS** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

2.17 **INJURY** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

i. **Acute Condition** means a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / Illness / Injury which leads to full recovery.

ii. **Chronic Condition** means a disease, Illness, or Injury that has one or more of the following characteristics

   a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

   b. it needs ongoing or long-term control or relief of symptoms

   c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. it continues indefinitely
e. it recurs or is likely to recur

2.18 **INPATIENT CARE** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.19 **INTENSIVE CARE UNIT (ICU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.20 **ICU (INTENSIVE CARE UNIT) CHARGES** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.21 **MEDICAL ADVICE** means Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.22 **MEDICAL EXPENSES** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.23 **MEDICALLY NECESSARY** treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the Illness or Injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;
- must confirm to the professional standards widely accepted in international medical practice or by the medical community in India.

2.24 **MEDICAL PRACTITIONER** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the insured or close family members.

2.25 **NETWORK HOSPITAL** means Hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured by a cashless facility.

2.26 **NON-NETWORK HOSPITAL** means any Hospital that is not part of the network.

2.27 **NOTIFICATION OF CLAIM** means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.

2.28 **PRE-EXISTING DISEASE (PED)** means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

2.29 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period preceding the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.30 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period immediately after the Insured Person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

2.31 QUALIFIED NURSE Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.32 REASONABLE AND CUSTOMARY CHARGES mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

2.33 RENEWAL means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

2.34 ROOM RENT means the amount charged by a Hospital for the occupancy of a bed per day (24 hours) basis and shall include associated medical expenses.

2.35 SUB-LIMIT means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit.

2.36 SURGERY OR SURGICAL PROCEDURE means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

SPECIFIC DEFINITIONS

2.37 AGE means age of the Insured person on last birthday as on date of commencement of the Policy.

2.38 ASSOCIATE MEDICAL EXPENSES means medical expenses such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

2.39 AYUSH TREATMENT refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.40 **BREAK IN POLICY** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

2.41 **FLOATER BENEFIT** means the Sum Insured as specified for a particular Insured and the members of his / her family as covered under the policy and is available for any or all the members of his / her family for one or more claims during the tenure of the policy.

2.42 **INSURED PERSON** means person(s) named in the schedule of the Policy.

2.43 **POLICY** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

2.44 **POLICY PERIOD** means period of one policy year as mentioned in the schedule for which the Policy is issued.

2.45 **POLICY SCHEDULE** means the Policy Schedule attached to and forming part of Policy.

2.46 **POLICY YEAR** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

2.47 **SUM INSURED** is the maximum amount of coverage opted for each Insured Person and shown in the Schedule.

2.48 **THIRD PARTY ADMINISTRATORS (TPA)** means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

2.49 **WAITING PERIOD** means a period from the inception of this Policy during which specified diseases / treatments are not covered. On completion of the period, diseases / treatments shall be covered provided the Policy has been continuously renewed without any break.

3.0 BENEFITS COVERED UNDER THE POLICY

NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed here on the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any Illness (herein defined)or sustain any Injury (herein defined) and if such Injury shall require any such Insured Person, upon the advice of a duly qualified Medical practitioner (herein defined) or a surgeon to incur Medical Expenses/Surgery at any Hospital / Day Care Center (herein defined)in India as an Inpatient, the Company will pay to the Insured Person the amount of such expenses as good fall under different heads mentioned below, and as are Reasonably and Customarily, and Medically Necessarily incurred thereof by or on behalf of such Insured Person.

3.1 Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of Sum Insured per day.

3.2 Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, not exceeding 2% of the sum insured per day.

3.3 Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

3.4 Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

3.5 Pre-hospitalization medical charges up to 30 days period.

3.6 Post-hospitalization medical charges up to 60 days period.

NOTE: SUB-LIMIT CLAUSE

1. **Proportionate Deduction:** Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on

    1. Cost of Pharmacy and Consumables
    2. Cost of Implants and Medical Devices
    3. Cost of Diagnostics.

    Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

2. No payment shall be made under 3.3 other than as part of the hospitalization bill.

3. However, the bills raised by Surgeon, Anesthetist directly and not included in the hospitalization bill may be reimbursed in the following manner:

    a. The reasonable, customary and Medically Necessary Surgeon fee and Anesthetist fee would be reimbursed, limited to the maximum of 25% of Sum Insured. The payment shall be reimbursed provided the insured pays such fee(s) through cheque and the Surgeon / Anesthetist provides a numbered bill. Bills given on letter-head of the Surgeon, Anesthetist would not be entertained.

    b. Fees paid in cash will be reimbursed up to a limit of Rs. 10,000/- only, provided the Surgeon/Anesthetist provides a numbered bill.

(N.B: Company's Liability in respect of all claims admitted during the Policy Period shall not exceed the Sum Insured per person mentioned in the schedule. In case of Floater basis, the limit shall apply to the Floater Sum Insured and not to per person.)

3.7 **AYUSH:** Expenses incurred for Ayurvedic / Homeopathic / Unani Treatment are admissible up to 25% of the sum insured provided the treatment for Illness and accidental injuries, is taken in AYUSH Hospital.

3.8 Ambulances services – 1.0 % of the sum insured or actual, whichever is less, subject to maximum of Rs. 2,500/- in case patient has to be shifted from residence to hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

3.9 Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. The Company's liability towards expenses incurred on the donor and the insured recipient shall not exceed the sum insured of the insured person receiving the organ.

3.10 SPECIFIC COVERAGES:

a) **Impairment of Persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 25,000 per policy period, subject to it arising during treatment of covered illness for an admissible claim. This amount shall be part of the Sum Insured.

b) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract). Such expenses shall be payable if required in conjunction to an admissible claim and shall be within the Sum insured

c) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.

d) **Age Related Macular Degeneration (ARMD)** is covered after 48 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of 10% of Sum Insured, maximum upto Rs. 75,000 per policy period. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

e) **Behavioural and Neuro Developmental Disorders**: Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

f) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

<u>Note:</u> For the coverages defined in 3.11 (a) to (f), waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020 or date of inception of first policy, whichever is later. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

g) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** We shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 48 months with a sub-limit up to 25% of Sum Insured per policy period.

The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalisation as per the treating Psychiatrist's advice

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions – aggressive / violent behavior or hallucinations, incoherent talking or agitation.
3. Schizophrenia - esp. Psychotic episodes.
4. Bipolar disorder - manic phase.

Treatment of any Injury due to Suicidality shall not be covered.

Condition

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

Exclusions

Any kind of Psychological counselling, cognitive / family / group / behavior / palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

Note: For the coverages defined in 3.11 (g), waiting period shall be applicable for both New and Existing Policyholders w.e.f 16th August 2018 or date of inception of first policy, whichever is later. This Coverage shall only be available after completion of the said waiting period.

3.11 COVERAGE FOR MODERN TREATMENTS OR PROCEDURES: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S No	Treatment or Procedure	Limit (Per Policy Period)
3.12.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to Maximum Rs. 2 Lakh
3.12.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 2 Lakh
3.12.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 5 Lakh
3.12.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 1 Lakh.
3.12.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 2 Lakh.
3.12.6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.75,000.
3.12.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 5 Lakh.
3.12.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
3.12.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.

3.12.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
3.12.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
3.12.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.

4.0 EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of:

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declare

4.2 FIRST NINTY DAYS WAITING PERIOD (Code- Excl03)

a. Expenses related to the treatment of any illness within 90 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.3 **Permanent Exclusions:** Any medical expenses incurred for or arising out of:

4.4.1 INVESTIGATION & EVALUATION (Code- Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

4.4.2 REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with

activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

4.4.3 **OBESITY/ WEIGHT CONTROL (Code- Excl06)** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor
b. The surgery/Procedure conducted should be supported by clinical protocols
c. The member has to be 18 years of age or older and
d. Body Mass Index (BMI);
   1. greater than or equal to 40 or
   2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

4.4.4 **CHANGE-OF-GENDER TREATMENTS (Code- Excl07)**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4.5 **COSMETIC OR PLASTIC SURGERY (Code- Excl08)**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.4.6 **HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.

4.4.7 **BREACH OF LAW (Code- Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.4.8 **EXCLUDED PROVIDERS (Code-Excl11)**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.4.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

4.4.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

4.4.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

4.4.12 REFRACTIVE ERROR (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SPECIFIC EXCLUSIONS

4.4.16 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.4.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced

toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.4.18 Circumcision unless required to treat Injury or Illness.

4.4.19 Vaccination & Inoculation.

4.4.20 Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

4.4.21 All types of Dental treatments except arising out of an accident.

4.4.22 Convalescence, general debility.

4.4.23 Bodily injury or sickness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, attempted suicide.

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

4.4.24 Naturopathy Treatment.

4.4.25 Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.26 Stem cell implantation / surgery for other than those treatments mentioned in clause 3.12.12.

4.4.27 Domiciliary Hospitalization.

4.4.28 Treatment taken outside India.

4.4.29 Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.

4.4.30 Service charges or any other charges levied by hospital, except registration/admission charges.

4.4.31 Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

5.0 GENERAL TERMS AND CLAUSES:

5.1 MULTIPLE POLICIES:

1. In case of multiple policies taken by Insured Person during a period from the Company or one or more Insurers to indemnify treatment costs, Insured Person shall have the right to require a settlement of Insured Person's claim in terms of any of his/her policies. In all such cases the Company, if chosen by Insured Person, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.
2. Insured having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then We shall independently settle the claim subject to the terms and

conditions of this Policy.

3. If the amount to be claimed exceeds the Sum Insured under a single policy after, Insured Person shall have the right to choose Insurers from whom You wants to claim the balance amount.
4. Where an Insured has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen policy.

Note: The Insured Person must disclose such other insurance at the time of making a claim under this Policy.

5.2 FRAUD, MISREPRESENTATION, CONCEALMENT: The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his/her behalf.

5.3 RENEWAL CLAUSE: The Company sends renewal notice as a matter of courtesy. If the insured does not receive the renewal notice it will not amount to any deficiency of service.

The Company shall not be responsible or liable for non-renewal of the policy due to non-receipt /delayed receipt of renewal notice or due to any other reason whatsoever.

We shall be entitled to decline renewal if:

a) Any fraud, moral hazard/misrepresentation or suppression by You or any one acting on Your behalf is found either in obtaining insurance or subsequently in relation thereto, or non-cooperation of the Insured Person, or
b) We have discontinued issue of the Policy, in which event You shall however have the option for renewal under any similar Policy being issued by Us; provided however, benefits payable shall be subject to the terms contained in such other Policy, or
c) You fail to remit Premium for renewal before expiry of the Policy Period. We may accept renewal of the Policy if it is effected within thirty days (grace period) of the expiry of the Policy Period. On such acceptance of renewal, we, however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalization commencing in the

interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy

5.4 **GRIEVANCE REDRESSAL:** In the event of Insured has any grievance relating to the insurance, Insured Personmay contact any of the Grievance Cells at Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact details of the office of the Insurance Ombudsman are provided in the Annexure II.

Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

5.5 **PREMIUM PAYMENT:** The premium payable under this policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.6 **PHYSICAL EXAMINATION:** Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or Illness requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company.

5.7 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

5.8 **DISCLAIMER OF CLAIM:** If the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.9 All medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

6.0 CASHLESS SERVICE THROUGH TPAS: Claims in respect of Cashless access services will be through the agreed list of network of hospital and is subject to pre-admission authorization. The TPA shall, upon getting the related medical information from the Insured Person / networkprovider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the hospital mentioning the sum guaranteed as payable also the ailment for which the person is seeking to be admittedas a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that denial of Cashless Access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his /her treating Medical Practitioners medical advice and later on submit the full claim papers to the TPA for reimbursement.

7.0 MEDICAL EXPENSES FOLLOWING UNDER TWO POLICY PERIODS: If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only. Sum Insured of the renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

8.0 REPUDIATION OF CLAIM: A claim, which is not covered under the Policy conditions, can be rejected. All the documents submitted to TPA shall be electronically collected by Us for settlement and denial of the claims by the appropriate authority.

With Our prior approval Communication of repudiation shall be sent to You, explicitly mentioning the grounds for repudiation, through Our TPA.

9.0 PROTECTION OF POLICY HOLDERS' INTEREST: This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation, 2017.

10.0 ARBITRATION: If we admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration.

The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

No reference to Arbitration shall be made unless We have Admitted our liability for a claim in writing.

If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

11.0 The expenses that are not covered in this policy are placed under List-I of Annexure-I. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-I respectively.

ANNEXURE I:

List I – Items for which coverage is not available in the policy

S No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT

44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER

52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

S No	Item
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES

35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

S No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

S No	Item
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP - COST
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG